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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ETHEL D. GIPSON, aka ETHEL DELLORICE GIPSON** **24094 Hollyoak, Apt. C** **Aliso Viejo, CA 92656** **Registered Nurse License No. 301198** Respondent.	Case No. 2012-46 **ACCUSATION**

Complainant alleges:

PARTIES

1. Complainant Louise R. Bailey, M.Ed., RN brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs.

2. On or about March 31, 1979, the Board issued Registered Nurse license number 301198 (license) to Respondent Ethel D. Gipson, aka Ethel Dellorice Gipson. The license was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2012, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code).

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence or gross negligence in carrying out usual certified or licensed nursing functions.
>
> . . . .

REGULATORY PROVISIONS

7. California Code of Regulations, title 16, (Regulations) section 1442, states:

> As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

8. Regulations, section 1443, states:

> As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

9. Regulations, section 1443.5, states:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COST RECOVERY

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTS

11. Respondent was employed by the California Department of Corrections and Rehabilitation (CDCR) as a registered nurse at California Institution for Women (CIW), a correctional facility in Corona, California, from approximately 2003 until she resigned from CDCR on April 21, 2011, as part of a State Personnel Board action settlement.

12. On or about June 5, 2008, the Board received a complaint from G.V., one of Respondent's former supervisors at CIW. In her complaint, G.V. alleged that since beginning her

employment by CDCR she had multiple issues with Respondent's unsafe patient care, negligence and incompetence in performing her nursing duties. The Board referred the matter for investigation and the investigation and Board expert's analysis of its findings revealed the following.

APRIL 5-6, 2007 INCIDENT

13. On April 5-6, 2007, Respondent was on duty and was assigned to care for Patient 1 (P1). Respondent did not follow physician's orders calling for two types of insulin to be administered to P1 hours apart in separate doses. Instead, Respondent administered both doses of insulin at the same time and as a result the patient had to be monitored and observed for several hours to ensure she suffered no adverse reaction. When Respondent was questioned about her actions, she lied and stated that she did measure the patient's blood glucose level prior to administering the insulin, when, in fact, review of the patient's medical records confirmed she had not been tested. When charting the administration of the insulin doses, Respondent entered false information on the Medication Administration Record (MAR) reflecting that she administered them at different times when, in fact, she administered them simultaneously. After Respondent realized her error, she telephoned the physician for orders and/or instructions. The physician ordered Respondent to take the patient's "blood sugars now" and Respondent wrote these orders on the patient's form. However, Respondent did not test the patient and did not record her blood sugar reading. The patient was then ordered to be sent to the Out Patient Housing Unit (OPHU), but Respondent sent the patient to the Triage Treatment Area.

DECEMBER 28, 2007 INCIDENT

14. On December 28, 2007, Respondent was on duty and assigned to care for Patient 2 (P2). Respondent documented a physician's order for P2 to be transported via ambulance to Chino Valley Medical Center and to be placed on oxygen. However, Respondent did not administer the oxygen and did not contact the ambulance for transport. When Respondent was interviewed about her failure to follow the physician's orders, she responded, "There were no oxygen tanks in the OPHU," when, in fact, oxygen tanks were available.

DECEMBER 29, 2007 INCIDENT

15. On or about December 29, 2007, Respondent was on duty and assigned to care for Patient 3 (P3). Respondent was ordered to have P3 transported to Riverside County Regional Medical Center (RCRMC), but she did not follow the physician's orders. Respondent also did not follow protocol for the urgent condition of P3's chest pain, as she did not place the patient on oxygen, obtain an EKG, administer nitroglycerin, administer aspirin, start an IV, or monitor the patient pursuant to nursing protocol. When interviewed about these failures, Respondent claimed that the EKG machine was not available when the machine was, in fact, available and on the unit. When further questioned, Respondent also claimed that the patient was transported to RCRMC because of swelling in her extremities, when, in fact, Respondent documented that the patient had chest pain.

MARCH 7, 2008 INCIDENT

16. On or about March 7, 2008, Respondent was on duty and assigned to care for Patient 4 (P4). Respondent did not assess this neutopenic cancer patient after her return from the hospital. Respondent acknowledged that she received a report from a Certified Nursing Assistant (CNA) that the patient had abnormal vital signs. Because of the neutopenia, the patient was at increased risk of infection and Respondent should have performed a nursing assessment on the inmate. However, Respondent did not complete the assessment and went on her break expecting that a CNA would monitor the patient, further placing her at risk. By leaving the treatment area and intentionally ignoring the critical vital sign readings reported to her, and leaving the compromised patient in the care of unlicensed medical staff (CNA), Respondent was deliberately indifferent to P4 and CIW's medical, health and safety needs, and P4's civil rights as an inmate.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Incompetence)

17. Respondent is subject to disciplinary action under Code section 2761, subsection (a)(1), in that she was incompetent, as further defined by Regulations, sections 1443 and 1443.5, in carrying out usual certified or licensed nursing functions when she failed to perform skills essential to the kind of nursing action to be taken, and failed to delegate tasks to subordinates

based on the legal scopes of their practice and on the preparation and capability needed in the tasks delegated, and effectively supervising nursing care given by subordinates, as demonstrated by the following:

a. Respondent failed to follow physician's orders; and follow protocol for the urgent condition of chest pain by failing to place P3 on oxygen, obtain an EKG, administer nitroglycerin, administer aspirin, start an IV, or monitor P3 pursuant to nursing protocol on December 29, 2007, as detailed in paragraph 15; and

b. Respondent failed to assess P4, a neutopenic cancer patient, after her return from the hospital whom Respondent knew or should have known from a report given her by a CNA had abnormal vital signs and was at increased risk of infection; went on her break expecting that a CNA would monitor the patient, further placing her at risk; left the treatment area and intentionally ignored the critical vital sign readings reported to her, and left the compromised patient in the care of unlicensed medical staff (CNA) on March 7, 2008, as detailed in paragraph 16.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence)

18. Respondent is subject to disciplinary action under Code section 2761, subsection (a)(1) in that she was grossly negligent, as further defined by Regulations, section 1442, in extremely departing from the standard of care which would have ordinarily been exercised by a competent registered nurse, in her repeated failure to provide nursing care as required or failure to provide care in a single situation, and which Respondent knew or should have known could have jeopardized her patient's health or life, as demonstrated by the following:

a. Respondent failed to follow physician's orders calling for two types of insulin to be administered to P1 hours apart in separate doses; failed to measure P1's blood glucose level prior to administering her insulin, and then falsely claimed she had done so; entered false information on the MAR reflecting that she administered insulin at different times when, in fact, she administered them simultaneously; failed to test P1 and failed to record P1's blood sugar

reading, even after subsequently and specifically ordered by a physician to do so; and then sent P1 to the Triage Treatment Area on April 5-6, 2007, as detailed in paragraph 13;

b. Respondent failed to administer oxygen to P2 and failed to contact the ambulance for transport despite being ordered by a physician to do so, and then lied about her failure to do so on December 28, 2007, as detailed in paragraph 14;

c. Respondent failed to assess P4, a neutopenic cancer patient, after her return from the hospital whom Respondent knew or should have known from a report given her by a CNA had abnormal vital signs and was at increased risk of infection; and should have been given a nursing assessment by Respondent, who did not complete the assessment; went on her break expecting that a CNA would monitor the patient, further placing her at risk; left the treatment area and intentionally ignored the critical vital sign readings reported to her, leaving the compromised patient in the care of unlicensed medical staff (CNA), and thereby being deliberately indifferent to the patient and CIW's medical, health and safety needs and civil rights on March 7, 2008, as detailed in paragraph 16.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 301198, issued to Ethel D. Gipson, aka Ethel Dellorice Gipson

2. Ordering Ethel D. Gipson, aka Ethel Dellorice Gipson to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: July 21, 2011

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SD2011700053